Instructions: All fields with an asterisk (*) are required. Please press the Validate button once finished to validate that all data in the workbook is correct.

For each benefit listed, select if it is Covered or Not Covered. If a benefit is covered, fill out the additional information.

For any benefit that has different limitations or restrictions, answer "Yes" on the limitations and restrictions column, do not add rows.

			•		•	bottom of the sheet, you will not l	· ·			
Benefit	Covered*	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units	Other Limit Units Description	Minimum Stay	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?
	Required: Is benefit Covered or Not Covered	Required if benefit is Covered: Enter a Description, it may be the same as the Benefit name	Required if benefit is Covered: Select "Yes" if Quantitative Limit applies	Required if Quantitative Limit is "Yes": Enter Limit Quantity	Required if Quantitative Limit is "Yes": Select the correct limit units	Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description	Optional: Enter the Minimum Stay (in hours) as a whole number	Optional: Enter any Exclusions for this benefit	Optional: nter an Explanation for anything not listed	Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described
Primary Care Visit to Treat an Injury or Illness										
Specialist Visit										No
Other Practitioner Office Visit (Nurse, Physician Assistant)										
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)										
Outpatient Surgery Physician/Surgical Services										
Hospice Services										
Non-Emergency Care When Traveling Outside the U.S.										

Infertility Treatment

Routine Dental Services (Adult)

Long-Term/Custodial Nursing
Home Care

Private-Duty Nursing

Routine Eye Exam (Adult)

Urgent Care Centers or Facilities

Home Health Care Services

Emergency Room Services

Emergency
Transportation/Ambulance

Inpatient Hospital Services (e.g., Hospital Stay)

Inpatient Physician and Surgical Services

Bariatric Surgery

Cosmetic Surgery

Benefit	Covered*	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units	Other Limit Units Description	Minimum Stay	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?
	Required: Is benefit Covered or Not Covered	Required if benefit is Covered: Enter a Description, it may be the same as the Benefit name	Required if benefit is Covered: Select "Yes" if Quantitative Limit applies	Required if Quantitative Limit is "Yes": Enter Limit Quantity	Required if Quantitative Limit is "Yes": Select the correct limit units	Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description	Optional: Enter the Minimum Stay (in hours) as a whole number	Optional: Enter any Exclusions for this benefit	Optional: Enter an Explanation for anything not listed	Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described

Skilled Nursing Facility

Prenatal and Postnatal Care

Delivery and All Inpatient Services for Maternity Care

Mental/Behavioral Health
Outpatient Services

Mental/Behavioral Health Inpatient Services

Substance Abuse Disorder Outpatient Services

Substance Abuse Disorder Inpatient Services

Generic Drugs

Preferred Brand Drugs

Non-Preferred Brand Drugs

Specialty Drugs

Outpatient Rehabilitation Services

Habilitation Services

Chiropractic Care

Durable Medical Equipment

Hearing Aids

Diagnostic Test (X-Ray and Lab Work)

Imaging (CT/PET Scans, MRIs)

Preventive Care/Screening/Immunization

Routine Foot Care

Acupuncture

Weight Loss Programs

Benefit	Covered*	Benefit Description	Quantitative Limit on Service?	Limit Quantity	Limit Units	Other Limit Units Description	Minimum Stay	Exclusions	Explanation	Does this benefit have additional limitations or restrictions?
	Required: Is benefit Covered or Not Covered	Required if benefit is Covered: Enter a Description, it may be the same as the Benefit name	Required if benefit is Covered: Select "Yes" if Quantitative Limit applies	Required if Quantitative Limit is "Yes": Enter Limit Quantity	Required if Quantitative Limit is "Yes": Select the correct limit units	Required if "Other" Limit Unit: If a Limit Unit of "Other" was selected in Limit Units, enter a description	Optional: Enter the Minimum Stay (in hours) as a whole number	Optional: Enter any Exclusions for this benefit	Optional: Enter an Explanation for anything not listed	Required if benefit is Covered: Select "Yes" if there are additional limitations or restrictions that need to be described
Routine Eye Exam for Children										
Eye Glasses for Children										

Dental Check-Up for Children

Other

EHB Benchmark Temp

Bariatric Surgery

Cosmetic Surgery

Benefit	State Mandate Required?	Name of Mandated Benefit	Description of Benefit Mandates	Market Applicability	Enacted prior to 12/31/2011?	Citation Number	Citation URL
	Optional: Select "Yes" if the benefit is Mandated by the State	Optional: Enter the Name of the Mandated Benefit	Optional: Enter a Description for the Mandated Benefit	Optional: Enter the Market Applicability (such as Individual, Small Group, Large Group)	Optional: Select "Yes" if the Mandate was enacted prior to 12/31/2011	Optional: Enter the Citation Number	Optional: Enter the Citation URL
Primary Care Visit to Treat an Injury or Illness							
Specialist Visit							
Other Practitioner Office Visit (Nurse, Physician Assistant)							
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)							
Outpatient Surgery Physician/Surgical Services							
Hospice Services							
Non-Emergency Care When Traveling Outside the U.S.							
Routine Dental Services (Adult)							
Infertility Treatment							
Long-Term/Custodial Nursing Home Care							
Private-Duty Nursing							
Routine Eye Exam (Adult)							
Urgent Care Centers or Facilities							
Home Health Care Services							
Emergency Room Services							
Emergency Transportation/Ambulance							
Inpatient Hospital Services (e.g., Hospital Stay)							
Inpatient Physician and Surgical Services							

Benefit	State Mandate Required?	Name of Mandated Benefit	Description of Benefit Mandates	Market Applicability	Enacted prior to 12/31/2011?	Citation Number	Citation URL
	Optional: Select "Yes" if the benefit is Mandated by the State	Optional: Enter the Name of the Mandated Benefit	Optional: Enter a Description for the Mandated Benefit	Optional: Enter the Market Applicability (such as Individual, Small Group, Large Group)	Optional: Select "Yes" if the Mandate was enacted prior to 12/31/2011	Optional: Enter the Citation Number	Optional: Enter the Citation URL
Skilled Nursing Facility							
Prenatal and Postnatal Care							
Delivery and All Inpatient Services for Maternity Care							
Mental/Behavioral Health Outpatient Services							
Mental/Behavioral Health Inpatient Services							
Substance Abuse Disorder Outpatient Services							

Substance Abuse Disorder Inpatient Services

Generic Drugs

Preferred Brand Drugs

Non-Preferred Brand Drugs

Specialty Drugs

Outpatient Rehabilitation Services

Habilitation Services

Chiropractic Care

Durable Medical Equipment

Hearing Aids

Diagnostic Test (X-Ray and Lab Work)

Imaging (CT/PET Scans, MRIs)

Preventive Care/Screening/Immunization

Routine Foot Care

Acupuncture

Weight Loss Programs

Benefit	State Mandate Required?	Name of Mandated Benefit	Description of Benefit Mandates	Market Applicability	Enacted prior to 12/31/2011?	Citation Number	Citation URL
	Optional: Select "Yes" if the benefit is Mandated by the State	Optional: Enter the Name of the Mandated Benefit	Optional: Enter a Description for the Mandated Benefit	Optional: Enter the Market Applicability (such as Individual, Small Group, Large Group)	Optional: Select "Yes" if the Mandate was enacted prior to 12/31/2011	Optional: Enter the Citation Number	Optional: Enter the Citation URL
Routine Eye Exam for Children							
Eye Glasses for Children							
Dental Check-Up for Children							

Other